Information Exchange Workgroup
<mark>Draft Transcript</mark>
February 28, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody, and welcome to the Policy Committee's Information Exchange Workgroup. This call is scheduled to run from 10:00 a.m. to noon Eastern Time. It's a Federal Advisory Committee, so there will be opportunity at the end of the meeting for the public to make comment.

Let me do a quick roll call. Micky Tripathi?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Peter DeVault for Judy Faulkner?

Peter DeVault – Epic Systems – Project Manager
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Connie Delaney? Gayle Harrell? Deven McGraw?

Deven McGraw – Center for Democracy & Technology – Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Latanya Sweeney? Charles Kennedy? Paul Egerman?

Paul Egerman – Software Entrepreneur
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Jim Golden? Dave Goetz? Jonah Frohlich can be on for only part of the meeting. Steve Stack?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
George Hripcsak? He also can join for only part of it. Seth Foldy will not be able to join today. Jim Buehler? Walter Suarez?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I'm here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Ross? Hunt Blair? George Oestreich? Tim Andrews?

Tim Andrews
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Did I leave anyone off? Okay, with that I'll turn it over to Micky Tripathi.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Good morning, everyone. Welcome to the Information Exchange Workgroup. I hope everyone is in places where the weather is better than we're having in Boston, because it's truly miserable here. Today we're going to cover two things. One is we want to hear from the Provider Directory Taskforce, which has been diligently at work on the successor consideration to the entity level provider directory work that we presented back in December, and have been busily at work on the individual level provider directory issue. They have a set of recommendations for the entire workgroup to weigh in on … of the Policy Committee meeting this week. So we're going to ask Walter and Jonah to walk us through that. I think Jonah's going to join a little bit late, but Walter Suarez, who's the co-chair of the taskforce, is on, and I'll turn it over to him in a second.

After that, we will discuss the foundation and the planning for the in-person meeting that we're planning on having on March 15th, which will be a full day in-person meeting for us to go through the stage two, stage three meaningful use recommendations. To try to tease out and understand better what the health information exchange implications are with respect to the recommendations that are out there. And be able to go through it ourselves in a fair amount of detail and decide on a number of levels where we would like to weigh in with respect to the health information exchange aspects that are out there. We have some sort of structure slides to help us walk through that, and then David Lansky is going to walk through a grid that has been prepared with the Quality Measures Workgroup that he co-chairs. I think that will also be very helpful in helping us think through how exactly we want to think about those issues.

The goal for today with respect to the meaningful use conversation that we're talking about is really just to introduce the overview of what it is we want to tackle between now and then, "then" meaning March 15th. What we'll do from a co-chairs and ONC staff perspective is do some more analysis so that we're able to present the meaningful use recommendations that have been made so far and are out there for public comment. We'll be able to tease out the health information exchange implications of that and perhaps categorize it and slice and dice those recommendations in a way that will make it more amenable to the March 15th in-person meeting. For us to be able to think about health information exchange specifically rather than have to try to pull it out from the recommendations that are currently presented in public.

With that said, let me see if David has any other introductory comments or thoughts and then we'll turn it over to Walter and Jonah.

David Lansky – Pacific Business Group on Health – President & CEO
No. I really appreciate the work of the Provider Directory Committee. I think they've really taken us a long way and I'm looking forward to this discussion of it. Thanks.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Thank you. Walter, are you on?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, I am. Can you hear me?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. Terrific. Thanks.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
In turn, we thank very much our members of the taskforce who have been just incredible to work with over the past few months at least as we focused first on the entity level provider directory and then shifted to the individual level provider directory.

If we can move the slide to—I think the next item and then the next one and then one more, so this is the framework. Most of you probably know it by heart now of course. This is the framework that we used in … at the beginning of the process for ELPD for entity level and we used for individual level provider directory. We added a couple of clarification points on this one, specifically out of some of the discussions that we had during the development of the recommendation for individual level, the identification of participants and distinction between the participants in the provider directory, the individuals that would be actually listed in there, and the users of those directories. We've identified and defined the functions, the content, the offering requirements and the business model for ILPDs and then made recommendations on those as well as on some of the policy issues around the implementation of ILPDs.

This is our members of the workgroup, and again the taskforce. Again, on behalf of Jonah and myself I really want to thank everyone for sharing their expertise and their time in working through some of the very difficult issues that we dealt with in respect to ILPDs particularly and given the complexity of this level of provider directory. So thank you again to all our members of the taskforce.

As we head into the recommendations, I wanted to just start by describing, we included in the packet a glossary of terms in which we defined what a provider directory is and what we refer to as entity level and individual level and what are some of the core capabilities that are I believe supported by this directory. So in the case of the individual level provider directory, we basically define it as an electronic, searchable resource that will list information about individual providers. We have a separate ELPD, entity level provider directory, that lists information about entity level providers. These are individual providers that are involved in information exchanges, and this provider directory will be used to support secure and reliable routing of health information messages and exchanges, and the discoverability of some of the information about the individual providers that will help support the secure and reliable routing of information. By routing, we include both a send and receive kind of exchange as well as a query and retrieval kind of exchange.

That's primarily what I wanted to just introduce as the concept behind provider directories and individual level provider directories. Just one point of clarification before we get into the recommendations, the entity level provider directory, which we completed recommendations on and the Health IT Standards Committee is now submitting its work on the recommendations, is really primarily to support organization to organization exchanges. Where information about an organization that is going to be the recipient of a message or is going to be the recipient of a query will be able to be identified and the directory will be able to be used for secure routing.

The individual level provider directory in turn is focusing on instances where the identification of the individual provider is necessary, or the information that is available to the exchangers of the information—it could be the submitter of the information or the entity individual that is querying the information—includes information about the individual. It could be the primary care provider, the specialists. So this individual level provider directory will be able to be used to discover, if you will, information about that individual, including the entity or entities that this provider works at or provides services at. Then the exchanger, the submitter of this message or the individual that is querying the other entity will be able to then link the information they found on the individual level provider directory with information about the entity obtained from the entity level provider directory, and then perform the secure exchange, the secure routing. So that's what the individual level provider directory will provide, and as we go along the description of the recommendations and some of the items around functionality, there will be more information about it and then some assumptions.

We can start with a description of the recommendations, so we classified the recommendations on individual level provider directory generally into two categories, some recommended practices, and these are items that an entity will become or is establishing and operating an individual level provider directory will be using to operate this directory. Then some areas are required to enable basic interoperability, so for example states will have different use cases for ILPD usage and needs that will require different levels of content and functionality. What we're describing here is sort of a minimal basic level of standardization that will be needed in order to allow the interoperability across this ILPD and between the ILPD and the ELPD. So those are the two categories of recommendations we have.

We made certainly some assumptions here. It was very good actually that we started this whole work by focusing first on the entity level, so that gave us a door into the issues and complexities around provider directories in general, and then helped us describe more specifically what are the kinds of … where the ILPD, the individual level provider directory, would be needed. Some of the assumptions and some of the framing that we developed to describe the ILPD included this concept of, first of all, the scope of the ILPD being at the sub-national level. What that means is basically we're really considering the ILPDs as provider directories that are developed and established and operated at the local levels. There is interoperability between them. There's less of a national centralization, if you will, or centralizing the functions and the information that is maintained in these ILPDs.

Thus, the rigid conformance at a national level is really not necessary. We do think of course that there is a need to define some these basic level of standardization across ILPDs, but the degree to which there is a need for having it centralized, operation in ILPDs, we clearly saw that it was not necessary. And certainly a very difficult one to support and to maintain when you think of the scalability of the numbers of provider individuals that would be listed in this provider directory.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Just a question, and maybe it's just me, so I would love others' thoughts on this. That bullet point as I read it, "rigid conformance at the national level is not necessary," my initial reading of it actually made me think that you were saying the opposite, and I just wonder, again, if it's just me, but if what we're saying is that rigid conformance at the local level to national standards is not necessary. Isn't that right? But that there may be a national level set of conformance requirements that we might want all ILPDs to have. But if not, it wouldn't cover every aspect of what an ILPD is. Is that confusing other people, or is it just me?

M
Yes, I think your clarification is a good one, that local conformance to national standards is not necessary.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, I think that would be very helpful to add that clarification. There are three basic elements, as I understand it. There's the concept that we do believe there is a need to have some basic minimum level of standards that will allow ILPDs to interoperate. But they're just basic levels of standards, not a comprehensive set of standards. Then the second point, which is this rigid local conformance to comprehensive national standards is not necessary. I'm adding the word "comprehensive" there because I think we reached some consensus that there was at least a minimum level of standards that needed to be—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I agree with that. I just think that the bullet point doesn't really say that. I think the words that you just said make it clearer, which is something like comprehensive, it may be that it's the word "at," that "comprehensive conformance to a national standard is not necessary but there's some minimal conformance that we believe should be required," or something like that. It sounds like that's what you're trying to say, right?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, exactly. So we'll just add that concept there, so comprehensive, rigid conformance at the national level is not necessary, and then maybe some bullet there that says minimal conformance is needed to support interoperability.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Okay, good job. The other thing that we are very aware of, I think, and it has come up a number of times is ... this is a really important and immediate need because states are currently, through their HIE effort implementing ILPDs at different levels, in different ways. So the need to produce these recommendations is very critical and it's important, as we had discussed over the last week even, to make the recommendations not just for sort of a long term view of how this will work, but in a practical way how it will be able to be implemented immediately in the HIE ....

There's this contract of course, also the second bullet here, well, the first bullet we really are trying to focus on best practices for establishing and maintaining ILPDs and we have gathered some documentation that supports that. Then there's the concept of best practices of course for how HIEs and states are using local policy levers to create incentives for individuals to participate in these ILPDs. Those are—conceptually the way we see it is really listed in some of these best practices and allowing states to understand and to know and learn and we need to implement some these as practices across their … efforts.

The next slide covers a few additional assumptions. We talk about ILPD listings, which just basically provide enough information, the basic minimum information that will enable primarily the resolution of or the proper destination of a message. For example, if an ILPD returns multiple listings of where the individual is or maybe multiple individuals, then there's a way to, through the notice of the requestor distinguish which individual they're looking for. Then once they focus on one individual, there could be multiple locations that this person goes into, and so again the assumption is that the requestor will have sufficient information to determine which is the location they're looking for to perform this secure exchange. Then, as we'll talk about, there will be the ability to link the ILPD to the ELPD to access information about the location.

The ILPD lists, again, the location of the individual provider and the ILPD would have a relationship to the ELPD that would allow access to the entity level information on the ELPD for the entity, or those various entities where this individual practices. Maintenance and updates to the ILPD would be managed at the local level, though not really necessarily managed and supported at the national level. The primary value proposition here is the exchange—whether it has the ability to support secure routing of a clinical document where providers have only basic information about another provider. Here again about another individual provider, where the patient is going to be taken care and needs to locate where this provider is practicing, so they can route the document to the right location. Those were the assumptions. Let me stop there and see if there are any questions about these assumptions.

The next slide describes basically the value propositions that are linked to the use of ILPDs and the reason why ILPDs are important. Users can identify and verify the recipient information and then electronically link the ILPD instead of having to contact each recipient. It simplifies the workflow and improves and increases the automation processes, so that's one of the values of this ILPD. The user system no longer is responsible for maintaining its own ILPD, so there's an opportunity to share cost and improve the consistency of information and the quality of information.

The user of the system can determine what information exchange capabilities are available at each recipient. This is one of the pieces of information that will be expected to be maintained in the entries of these provider directories. So the individual that is starting the communication will know what kind of information exchange capability the entity, that is, the one that is intending to do the exchange has, for example, the kind of standards to transport a message content and formatting they support for exchanging and receiving a particular document.

This again enables more automation, reduces the need to establish individual contacts separately. When maintained in an up to date status any changes in the information exchange capabilities of the recipient of that exchange will be able to be recorded and the submitter, or the initiator of that communication, will be able to identify that new capability that you see here now. Then the user can potentially query the ILPD for additional information, some administrative facts, license information .... There are might be other benefits potentially into the future about the ILPDs, but again the primary purpose and the main functional capability we're looking at is the ability of these ILPDs to support secure routing of messages.

Let me stop there and see if there are any questions about these value propositions.

David Lansky – Pacific Business Group on Health – President & CEO
I just had one question about the third bullet. I didn't see it on the other slides. Do you anticipate that that requires national standards so that there's interoperability of the content when people are retrieving the capabilities list?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, I think that will be part of the standards that will be needed. Generally speaking, the information exchange capabilities will really be part of entity level provider directory, and we describe that specifically in the ELPD. In the ILPD, the most significant part would be which entity is individual practices and what that resolves. Then the connection between the ILPD and the ELPD will allow the initiator of the exchange to go to the appropriate ELPD record of that individual and discover those information exchange capabilities.

David Lansky – Pacific Business Group on Health – President & CEO
Okay, that makes sense. Thanks.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Here's where we start with the recommendations, and again, we're going to go with our original framework talking about participants, users, uses, content, and functional capabilities, etc. We'll start with the participants. Here what we've tried to describe is who we included in this ILPD. The recommendation is that participants are basically individuals who can be listed in an ILPD and should include all individual healthcare providers who are licensed or otherwise authorized by a state to provide healthcare services or support the health of populations. This would include all individual healthcare providers that are involved in health information exchanges and health information exchange transactions, whether they're the seekers of the information, the initiators of the exchange, or whether they're the receivers of the inquiry or request.

Again, the second condition of course is that this will be individuals listed, because they need to be at some point, or for some reason, identified at that individual level for the purposes of receiving or requesting this health information. Or that it is likely that the initiator of the exchange will have the individual level information and they need to do the ILPD search and identify the various locations and then link to the ELPD to obtain the information about the appropriate location. This is basically the description of who would be listed in this ILPD. So let me see if there are any questions here.

Then the next slide talks about the users, so who would be able to use these individual level provider directories. They should include, as is listed in this recommendation, the users with access to ILPD content should include clinicians and any support and administrative staff that is involved in these information exchanges. There is certainly the expectation that there will be some well-defined roles and rules based access policy for users and operators of ILPD services. This is something that at this point we envision it would not be really openly accessible, but would be a controlled access by individuals, both physicians and administrative staff, that will have the need and the access ability to seek information from the ILPD. The expectation is that the operators of ILPDs will put in place policies that would define individuals and roles of those individuals that will allow users to access information.

It should be set at the local level, as is pointed out in number two, and consider federal and state laws, regulations, and accepted practices. So we're acknowledging here that there are certainly requirements and controls and protection of information and restriction of access of information and that it's important to consider recent federal and state laws and regulations. We have some more information about this and the operating requirements that we will discuss a little later.

Then the third one is some sensitive content, information in this ILPD that could be considered sensitive information, like state license numbers, DEA numbers, and other numbers of the individual. This can certainly be restricted and user access control and unlimited access implemented for those pieces of sensitive content.

Those are the descriptions of the users as we see it here. Any questions or comments at this point?

David Lansky – Pacific Business Group on Health – President & CEO
Can you talk a little bit about the discussion you've had regarding public access to the directory. You talk about the need for rules and restrictions, but can you characterize what you think those rules and restrictions are going to need to look like?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, the way we see it is really this is probably a stepping stone process in which the first level of use and applicability of the provider directory will be limited to the routing capability and support. In order to do that, there will be a need to restrict that because some of the information will be potentially sensitive

content. The rules would be—we saw, first of all, that the local based rules, so rules that are developed by the operator of the ILPD. So they might vary depending on the use and content and applicability of the ILPD in each location, they will be rules based on entities, well individuals really, that are going to be registered and accepted to be able to access ILPD services.

There will be some expectation that operators of ILPD services will have some mechanism to identify and to authenticate, if you will, and confirm that an individual that is attempting to access ILPD services has the right to do so. We didn't get into operationally how ILPDs would get into the execution of this rules based access and policies, but generally speaking there will be some way of controlling access and authenticating the users.

David Lansky – Pacific Business Group on Health – President & CEO
I'm wondering about the use case. We're going to get to this in the other meaningful use applications, but if the patient wants to send information to their provider—medical documents from a third party or personal reports or whatever it is—they're not able directly in this scenario to access the directory. So I can imagine a set of third party mechanisms for doing that. But then I wonder about the proliferation of directories and the opportunity to get some harmonization of directories so that different use cases and users aren't using different mechanisms and maintaining multiple directories and so on. Is there a, you said stepping stone at the outset—?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes. The second step, I guess, of the stepping stone concept was that as this gets structured and put in place and operationalized and basically, it gets a stable implementation, clearly, there is an opportunity to create a … or a mechanism or some sort of a way to allow for some more open access to ILPD information. Again, this will be sort of like, okay, so we now have the full set of data elements in the ILPD, and that includes sensitive information. It includes the need to control access, but there could be a ... of that, if you will, but it has limited data elements sufficient for individuals when, in the use case I described, the patient would be able to identify a provider and send a document to that provider. Then they will be able to access the ILPD as well. So the way we see it, I think that will be a second stage in the evolution of these ILPDs.

David Lansky – Pacific Business Group on Health – President & CEO
What are the sensitive elements that are going to be in the directory that would make that more public use case more difficult to establish? What's the exposure that we're worried about, sensitive data or proprietary data? Because it sounds like—

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, there's certainly some ... the terms of HIPAA privacy, but not applying HIPAA privacy here, but there will be some individually identifiable information, individually in the sense of individual providers, including of course the name and known addresses. Then unique identifiers of this individual that might be considered to be sensitive and protected information in some cases, that would need to be protected mostly to avoid the risk of fraud or identity theft or those kinds of situations. So considering that, that was basically what we thought it would be important to start is into a rule based control or access control approach initially. Then again, in that role, there could be certainly a possibility of potential for a public version, if you will, of these ILPDs, a public interface of the ILPD service that will have some of this information or that will basically eliminate access to certain sensitive information.

But at this point I think that our goal was to support some of the vast majority of exchanges that occur between providers and between entities. We didn't create a use case in which the patient would be submitting information to a provider and would need to identify the location of that provider, and maybe I

should point out a third party mechanism to behind the scenes allow the patient to route the information to the appropriate provider.

Other questions or comments on this slide? Okay, then the next slide talks about the uses, and I'm going to speed up a little bit just because we have a lot of information to cover and I know we have only a limited time and we need to reserve time for the other items here. The uses—and we push all the use cases to the back of the presentation. They're all provided. We developed use case scenarios for the exchange of data both in a push and a pull type of situation—whether they involve the exchange of data between two clinics, a hospital and a clinic, or a public health agency looking at pushing information to individual providers. Or pulling information about a provider that they need to contact for a particular public health situation. We also created a lab to clinic exchange.

Now, all these scenarios, the title points to entity to entity exchanges, but in reality, we use the same title for the entity level provider directory for this scenario. But in the ILPD, in the individual level provider directory scenarios, what we describe is a situation in which the individual provider is known or needs to be identified in the exchange. The title of the scenario itself might be misleading in that sense in that it might give the impression that we're still talking about entity to entity exchanges, when in reality we're talking about exchanges in which an individual is actually identified, known, or needs to be identified.

In the discussions that we had just actually in the last week with the taskforce, there was a point brought up in that in reality the vast majority of exchanges really occur between entities in most cases, not the vast majority, but in many cases, the exchanges are between entities. Or, at the end of the day it's where an organization's system is sending a message to another organization and that other organization receiving it and then opening it and identifying, routing it appropriately inside the organization to the appropriate individual, or hosting the information content in the appropriate directory of the right person and those kinds of things .... So the description of these scenarios includes that kind of sequence in which there's an individual that is known or identified and then they ultimately go to the entity that is going to be exchanging the information, and that's the reason why this connection between the individual level provider directory and the entity level provider directory is so important. I'm sure we'll talk a little more about that connection in a couple of slides further down.

Some of the common threads across the scenarios included the submitter needs to send a message to an individual provider, the submitter has some information on the individual but does not know the individual's location where that information would be sent, and so the ILPD is just to identify all possible locations. Then with additional information that's submitted, identify and select the appropriate location and then it goes to the ELPD to obtain the information exchange capabilities and discover, if you will, the security type of credentials that will allow that exchange to happen. Then the submitter will be able to send and route securely the information to the individual provider at the identified location. So that's basically the sequence, the common thread across all these scenarios.

There are certainly a number of privacy and security considerations. The focus here about privacy is it relates to privacy of the information of the individual provider as well as privacy about any information of a patient or a consumer, as all use cases are certainly contingent on following federal and state privacy laws and rules and restrictions around the exchange of information. The pull use case certainly adds an extra layer of complexity that creates a much stronger need for secure authentication and secure verification of the entity that is where the individual is requesting information, in this case the pull use case is an individual tried to access information. There is also a provider authentication requirement, which incidentally the Privacy and Security Tiger Team has made recommendations about and the Health IT Standards Committee is already digging in to develop recommendations around digital certificates, for

example, that will be used in this kind of situation, in pull type of situations. Not just in pull situations, but in pull situations where there's an individual trying to access information from another source.

This is content and description of the use cases. Let me stop there and see if there are questions. We can go into the use case descriptions if we need to now or we can go through the other recommendations and then come back to the use case, if you want to. Let me stop there and see if there are any comments.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
The … that Jonah and I, you may not have seen all of this, but we had a discussion about adding a bullet on one of these slides, and this slide set looks different than the one that we had last week. The bullet had to do with the ILPD being able to query the ELPDs for organizations. Again, this is the point that I've raised that I think there's going to be a number of use cases where, say, a physician in a rural community wants to send someone in to the hospital in a bigger city. So they just want to push a CCR or CCD or information of some sort to Price Hospital and they don't know which doctor or clinician it's going to go to and it's irrelevant to them. They just want it to go to that hospital's EMR. There is no individual. There will never be a search for an individual clinician. So in those cases it's really just a push to an entity that appropriately can receive information. We don't really capture that, I don't think, in our use cases. Or do you feel otherwise?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Steve, I think that is one of the use cases for the ELPD, the entity level provider directory, right, because that is the situation where the submitter of a document doesn't need to know the name or the specific receiver, individual that is going to be expected to receive a document, but know that the entity may still receive it. So the ELPD can directly be accessed to find that entity and obtain all the information about the entity to do the secure exchange.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I accept that. That makes sense. But then how does this work in practice as far as how would someone access information? I can imagine if you're affiliated with an ILPD you might query the ILPD if you're looking for an individual clinician, but if you're looking for an institution then you also have to have a separate relationship directly with an ELPD.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
The ELPD would be a separate directory, the way we see it. Then the recommendation has been that there will be certainly more of a national structure that will support the registration. We talked about the ability to have registrars that will allow entities to register the entity or the organization into the ELPD, and that information, get that into the national ELPD and a provider directory that is able to be searched and accessed on its own. There's no intent that the only way to access an ELPD will be through an ILPD.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
So since the ILPD is a white pages whose principal purpose, although there may be other secondary uses, I understand, but its principal purpose is to be able to discreetly identify a specific clinician and then to link to its ELPD listing. But for organizations, facilities, institutions, things like that, you'd end up querying directly in ELPD. So how do you envision—? I'm just trying to think, it may not be unwieldy, overly complex, or clumsy, but the fact that you have essentially the ELPD is the sole routing directory for all of this stuff, but the ELPD is both the routing directory for everything, both individuals and institutions. It is also a white pages, whereas, the ILPD is just a white pages. Is that reasonable?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO

I think you're correct in that the ELPD will be the main routing for entity exchanges. The ELPD would not have individuals listed in it. The ILPD would have the relationship to the ELPD, but I'm not sure that we have a desire or expect that an ELPD entry, say, hospital X, would then have a connection to the ILPD and then to all the individuals that are linked to that ELPD. You can do the one-way, if you will, from ILPD to ELPD query, or connection, if you will, so one ILPD record, my record in the ILPD, that record will be connected to ten different records in the ELPD ... in ten different places. But if I go to the ELPD to one of those ten places, I'm not sure that we have created a connection backwards, if you will, to allow through the ELPD access to all the providers that are in that particular entity by connecting it back to the ILPD.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
That's okay. I wasn't worried too much about that specific scenario you just outlined. I was just making sure that there's a way for people who want to send information or pull information from institutions without having any specific clinician's name, if there's a way to do that. I think you're clearly envisioning that with the ELPD being a direct source you go to for that purpose.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Exactly, yes.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Thanks, and I'll let go of the other point I mentioned, so thank you.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Any other questions about the uses?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Maybe we're going to get to this later, but it sounds like the direction we've been heading in is that the ELPD is a nationally available service that will adhere to a certain relatively strict set of standards and will be made available under certain terms that have yet to be defined. There are various ways that it can be operationalized and I think we've even discussed whether it could be a lever for governance as we think about Nationwide Health Information Network governance, and perhaps it could be thought of in that way. As we think about ILPDs, that is more, as we've noted, a set of best practices and perhaps some participation requirements or some service use requirements as it relates to their being able to consume or use the ELPDs. First off, is that correct? Is that a correct way of thinking about it? Second, how do we think about who could actually have a qualifying ILPD, if we think of qualifying meaning that they're able to consume services offered by the ELPD? Is that something we're going to get to later?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
We will get into that, absolutely into that later. You're right, that is the way we've been thinking about the ELPD being more of a national available service. The ILPD and the recommendations about the ILPD are much more recommendations directed to the potential ILPD operators.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, because there are some very specific tactical things, and again we can hold these off until later. One, there are already many ILPDs in existence and there's no ELPD right now, so there's a timing and synchronization issue there about how we might want to think about how this actually gets operationalized in the market. Then second is the question of which ILPDs would qualify and how do we think about those policies, because again, Intermountain Healthcare has huge ILPDs already, as does the New England Health Information Exchange, as well as IHIE in Indiana, as well as Epic, and eClinicalWorks, and Allscripts.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Exactly. Those questions about who would qualify, and as you point out, there are many ILPDs already in place that are, in many cases, internal for the entities that use them. The opportunity for these to find what are the basic elements that make them interoperate and being able to be queried and exchanged from outside not known sources, individuals or entities. So yes, we will get into those discussions as we get into the recommendations.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
All right, great. Sorry to interrupt.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Let's go to the next slide then and talk about content. In the content here, we're looking at the kind of data that would be expected to be included. We didn't really define the specifics. We describe it in general and the categories of information that we expect. So the recommendations basically are individual providers, not entities, organizations should be certainly the ones listed in the ELPD, and the provider types listed should conform to federal and state rules about who is the licensed or otherwise authorized individual able to provide healthcare services. The information that we described needed for an individual to be included in the ILPD would be the demographics, including things like ..., provider type, specialty, name and address of practicing locations, all the various possible ones, practice phone number, e-mail address, hospital affiliation, and other things. Then some of the potentially sensitive identifiers would be things like NPI, the DEA, and the state license number.

We have noticed that some of this information is public information too, so there are some that are not necessarily public and that are valuable in order to be able to correctly identify an individual. We limited really the expectation of the content to the basic data that will be needed in order to allow for an individual to be correctly identified and a listing of all the places where an individual practices, to serve really the intended purpose of the information should be … representing all providers ... and certainly accurate. There should be limited access to and tight policies regarding access to potential sensitive identifiers, again to reduce or minimize the risk of fraud and identity theft, and then existing sources of content that would allow operators of ILPDs to verify, validate, and even load information would be state license board, vendors, health plans, others, national databases with provider information. Above all ensuring the data integrity will be paramount to being able to have these ILPDs be successful. It may be necessary to use multiple data sources to populate initially in ILPD content, and entities will be able to populate, verify, update information as well so that that will be part of what will be able to be done.

Again, the basic elements on the content side are the bare bones, if you will, data that is needed to correctly identify an individual and link that individual to various locations or practices. Those are the two primary conditions, if you will, for the data content. The intent is not to include all sorts of other information at this point in this ILPD, but concentrate on the minimum data set that will be needed in order to allow for appropriate identification. Some of the ILPDs that Micky referred to that already exist have a lot more information about individual providers in their directories, but the expectation is that this minimum data will be the one that would allow, for example, the interoperability of those ... with other ILPDs outside of the organization. Any questions about the content?

Let's go to the functional capabilities. In the next slide, the functional capabilities, basically these are very similar to the functional capabilities we identified for the ELPD except that there are a few connections I guess to the ELPD where the information about the entities reside. The functional capability that the ILPD would support would be direct exchanges and functions, so the send/receive, as well as query/retrieve provide basic "discoverability" of an individual provider and their practice location. The service should support basically querying capabilities at multiple levels, so practice location, provider

name, specialty, different ways to get to the provider that is being looked for, or confirm—basically match the right provider we have with say the name and the specialty only.

Then provide basic discoverability and links between the individual provider and its ELPD listing, and through that, in the ELPD, is where the information exchange capabilities and security credentialed discoverability exist. It's not really in the ILPD where the information about entity level credentials for submission of messages will reside. It's really in the ELPD. We're not intending or expecting to duplicate information between the two … very dynamic entities.

Then the other element that needs to be supported is then a strong support on audit trail capability, to know, because this is restricted access, know who is accessing the system and what are the items or entries or records that have been accessed by ..., so strong audit trail capabilities and other functional capabilities of the ILPD. We'll talk more about this in the recommendations on the operational side, what we mean by that.

Any questions about the basic functional capabilities that we recommend for ILPDs? Okay, let's go to the next slide.

(Noise in background where speaker is)

The next slide is a sequence of recommendations and operating requirements. We have a total of 11 recommendations and operational requirements, which I think this is one of the places where we really make a difference between our recommendations on the ELPD and the … recommendations. As we will see, the recommendations are directed to the ILPD operators in that they should do each of these and comply or put in place things. So this is where the recommendations about this is how they should make things operate in the ILPD come into play with respect to the ability for the ILPD to interoperate with each other.

Let's start with the first ... here. Number one is that the ILPD operator should establish … policies and procedures and provide structure and a secure mechanism for individual providers to enroll and verify information used populate the ILPD. So this is a mechanism for kind of the onboarding of individual providers into the system, so defined policy on procedures and they structure and secure mechanisms that allow that to happen. That's not just enroll and verify, but certainly maintain it ... in a minute.

Number two, establish policies and procedures to verify, as appropriate, the information provided by individuals enrolling in the ILPD. So some mechanism to verify the content of that information, so cross … verification with licensing boards and .... Data elements included should at least meet the minimum data set recommended by ONC, so this is the recommendation that we're making about the data elements. The ILPD operator could have many more data elements but we're saying that a minimum data set should be the one we are recommending. They should follow national standards in terms of the definition and content of the minimum data set.

Number four is establish policies and procedures that define who can access and use the ILPD and which data they can access, and then including policies on the sensitive information, what are the restricted access procedures to protect that sensitive information. Then number five is the ILPD operators should ensure that the ILPD is able to interoperate with other ILPDs that are developed and operated in a manner that follow … recommendations. So those are the first five. Let me stop there and see if there are any reactions or comments.

The next slide talks about three more recommendations. It says the ILPD operator should provide a mechanism for individuals listed in the ILPD or the delegated individual that has authority to … that or ... staff, or an administrative support person to correct or update lists of the information on the ILPD about that individual. An update on resolution process and change from policy should be put into place as well to manage change request .... This is all about the mechanism to allow access to an ILPD record for the purposes of updating ... information.

Number seven is establish policies that require individuals listed in the ILPD to update periodically their information. So this is a requirement based on, for example, at least three times per year or as an individual provider changes practice location ... and do it within certain time frames after the change had happened. Because again this is the place where practices will be discovered, if you will, locations of that individual we discovered and then linked back to the ELPD. Then number eight, develop and put in place audit trail policies and procedures to track access and use, and be able to investigate inappropriate use and breaches of …. Those are three more operational requirement recommendations for ILPD. Any questions on—?

Okay, the next slide talks about the last three, so number nine is to ensure that there is accountability and a shared responsibility in managing provider listings, delegating much of the responsibility of maintaining the current listings to the providers, other delegated entities or … staff. Number ten is develop procedures and set of policies to establish appropriate linkages between the ILPD and the ELPD, updated providers ILPD listing, they're updated to the ELPD listing and allow interactive access to the ELPD information about an entity that's ... an individual but is listed in the ILPD. This is where the connection between the ILPD and the ELPD will be established and the define policies and procedures be maintain and update it.

Then the last one that we have in terms of operational requirements is that ILPD operators should implement security policies and procedures that ensures that A) data contained in the ILPD is appropriately protected from unauthorized changes; B) only authorized individuals have access to the data for purposes of updating changes; and C) access information contained on the ILPD by ... users appropriately match. These are all eleven operational requirement recommendations for ILPD. Again, we constructed this in more of a set of recommendations directed to the ILPD operator, so I'm going to stop there and see if there's any questions or comments on those.

Okay, so we have a couple more slides here. The next slide talks about the cost and business model considerations. Some of the considerations we have about this is without sharing responsibility for maintaining the ... of the directory listing, the cost of keeping the content can become unsupportable. So really this is directed to the fact that the responsibility for maintaining it rests directly on the individuals that are listed and their respective entities ... authority individuals. It's really a shared responsibility for the maintenance of this information. Operators then, we point out, should consider models where providers are the delegated entity that are accountable for the accuracy of the listing.

The other consideration is that ILPDs have limited intrinsic value in themselves. ILPD operators need to consider what services are needed and valued in the market and how the ILPD supports the service and increases the value proposition. There's this concept that there are potentially additional services that can be supported through an ILPD to increase the value proposition for the ILPD itself.

Then the third consideration here is that services outside of what may be required to fulfill meaningful use requirements that require … directory should be considered by the ILPD operators. So things like credentialing and research are the elements that could be this other element that increased the value proposition of ILPD that can be supported by the ILPD operator. Certainly, we didn't get into that. Our

primary intent, again, was to create some recommendations that will make ILPDs able to support secure routing type messages. There's again a number of other potential users that an ILPD operator can give to the ELPD to make the value increase and ... the other benefits of it for the …. Any questions about those?

Okay, let's go to the last slide that I have, and these are policy recommendations that are specific to some of the initial development of ILPDs or initial .... The first is a recommendation to the Health IT Standards Committee that they should be directed to identify and recommend to ONC technical, interoperable standards, including message and content standards for ILPD consistent with the HIT Policy Committee recommendations in ILPD. So assuming that the HIT Policy Committee approves— presuming that our workgroup here approves them, then this will go to the HIT Standards Committee for them to look at identifying and recommending technical interoperable standards that will be used by ILPD. They will be doing that in conjunction with the work around the … framework ... to identify and establish a standard.

The second recommendation is CMS should make in systems like NLR and PECOS, and these are data systems that CMS maintains in which they register and maintain information about individual providers. They should make those available to ILPD services that are funded through the state HIE cooperative agreement .... So this is a way to support state HIE cooperative agreements, funded HIEs. This is the way to support the establishment and/or the validation of population of their ILPDs by being able to access NLR and PECOS from CMS.

Number three states using HIE cooperative agreement funds to salvage the state level ILPD should make these resources available to participants in private and public sponsored networks. So basically the concept is that the ILPD being developed by states that have been receiving HIE cooperative agreement funds and that will be using some of those funds to create these ILPDs, to make those available to participants in private and public sponsored networks.

Then the last one, CMS should consider how they could require state agencies to incorporate ILPD use as an approved Medicaid HIT plan and fund state EHR incentive programs. Again, this is finding ways in which some of the ONC national health IT initiatives can be leveraged to direct some of the programs to participate and implement ILPDs that are consistent with recommendations in these policy standards that would be developed and established by the ... Standards Committee.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
First off, is there background noise where you are?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I'm sorry. There is a little bit of noise behind me.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
That's fine.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I'm sorry. There is someone else probably talking around here.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Understood.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO

This is my last slide, so this is a perfect segue. The last couple of points are—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I'm sorry, Walter. I had another question.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Go ahead.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
On item two, could you elaborate a little bit on what the thoughts are about making content available? What would that mean that they would actually be interoperable so they could dynamically update content, or is that just getting too far into the weeds of what the Standards Committee might consider there? Then the second question is related to number three. I just wanted to get a sense from you of what was the thinking behind number three? Was the concern that you're putting your finger on or trying to be a little bit more directive about that resources would not be made available to other entities except for the cooperative agreement grantees themselves? Or that it wouldn't be made available to private versus publicly sponsored? I can see two angles on that and I'm just wondering what the—

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Sure, good questions. I'll start and I'm sure Jonah will have some comments on this too. On the first question, point number two, the concept was to do two things. One is for CMS to allow access to the NLR and PECOS to populate at the starting point that a new ILPD is coming out, so a quick way to populate the ILPD with reliable information is accessing reliable sources such as PECOS, NLR, even the NPI system. So the concept was that by allowing that ... access, new ILPDs could populate quickly their information there, and then the second part is also to be able to update and maintain more reliably information as the ILPD becomes operational. So it was sort of both the ability to populate in the first instance and then to be able to maintain the ILPD with a reliable source. So that was the thinking behind number two. Then number three I think the point that was being made was that, so for example an entity that is not participating in the federally funded state HIE, but it's still open in the state, be able to access that ILPD developed through the state HIE cooperative agreement. I think these were the two elements. Jonah might have some more insights about this.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes, that was essentially it. Number two is that the content that populates PECOS and NLR should be made available to others like state HIE cooperative agreement participants to populate their directories. The third was really that the cooperative agreement recipients also consider how they can leverage their investment as they develop ILPDs and make them available as services to others. Both whether they're an existing network, an HIE, as a noun, in the state, or whether they're a private network that also needs an ILPD, so to consider it as a business proposition to leverage our investment and create a service that others can use.

David Lansky – Pacific Business Group on Health – President & CEO
Jonah, just to clarify that, it's not explicit and I think it's probably not implicit that this is also the opportunity for generating revenue in doing so. But the fact that there's federal funding stimulating the development of the ILPD to the state doesn't mean the state or the agency implementing it can't go ahead and develop a reasonable cost business model, right?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
That's right, absolutely.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I just wonder if there's a clarification in number three. When I read it, I guess because it says "funds" and then refers to resources a little bit later, I read that to mean that they should make available funds, especially subsidize the creation of other sub-ILPD activities in their state. But it sounds like what you're saying is that whatever gets created, we want to make sure that those services are available to all of us.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Right, and per David's point specifically, that's right, that this is a business opportunity and a sustainability opportunity for these state HIEs.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
That's right. We should make that change.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, I think adding perhaps the words "provider directory resources," so make this "provider directory resources available to participants," so that it doesn't get confused with funding.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, either sources or services or something like that. Number two, is this just another way of saying that we think that NLR and PECOS should be interoperable with the set of standards that are promulgated for ELPD and the ILPDs?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
I think that's a good suggestion. I think more than anything, and I think it's implied by the notion that the data within NLR and PECOS should be made available to states to populate their ILPDs. If we're saying that, then I think we're saying that they should probably conform to some kind of a standard as well.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, because if we're saying content, sort of the static one-time feeds whatever nascent ILPD activity we're talking about, but then I think heard Walter say update and maintain as well.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Exactly, yes. Conceptually, they should be able to interoperate as well with ILPDs, and ELPDs for that matter. They also maintain a very reliable national ... level registry system .... Okay, any other questions on this slide, or this last set of recommendations?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Sorry, and I forget—I would have to look back at the ELPD recommendations, but I'm wondering if there's another policy recommendation here. Maybe it was already covered in the ELPD, but something along the lines of that there is a set of participation requirements. I'm just going to think out loud so it's not going to come out right, but that a part of what we hope will be the hook to create ILPDs that are locally generated and locally useful, but do start to create this network and living, breathing, dynamic network of ILPD, ELPD kinds of connections. That there's a set of participation requirements for anyone who wants to have their ILPD connected to the ELPD, where the idea would be if the ELPD is used first as a governance mechanism, let's say, and we, again, the NHIN workgroup is where they are. I guess we

have to figure out what the interaction is with them to have that considered further. But also to the extent that the ELPD that's seen as something valuable, maybe that's a policy lever that would be valuable to help. To both spur the creation of and orchestrate in a loose but relevant way the ILPDs that get created, both the ones that are already in existence, as well as the nascent ones that might get created through the federal funding.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I think that's a great point to be made as a recommendation, … on the ELPD because I think we can ... ILPD, but I think we can add certainly in this as a number five perhaps. Say that recommendation that points to the fact that those ILPD operators that want to see their ILPD interoperate with the ELPD and will be expected to meet this better participation requirement, both in terms of meeting the recommended 11 or so operating requirements, as well as meeting additional requirements about linking the ILPD with the ELPD. We can add that as a number five perhaps.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
What do other people think about that? It certainly does beg a lot of questions then about how enforcement happens monitoring all of that.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I'm sorry to join late, and please let me know if this has already been covered. I think one of the things we're starting to hear about, there are certain organizations where the ILPDs that they've developed is really a huge asset. In questioning about willingness to open it up and make it interoperable, it begs a lot of questions around what the business piece is for am I then making that asset available to everyone. I think we're going to need to really work through the motivations people have to participate. One thing is just to say you're required to do it off the standard, but I think we really need to think through the model of the future world, where there's more motivation to connect, including connecting your assets, than there is motivation to be closed. Some of that is our policy levers, but the only thing I would be cautious about is not layering on a bunch of technical specifications to solve a policy problem.

So I wish I had exactly the right solution to it. I don't think I do. But I'm worried about loan motivations. We can't mandate, maybe we can, there are some mechanisms where we could, if highly encouraged and certainly, in the context of meaningful use we can record standards. But we need to be very aware of the levels of motivation to do different things and how we add on requirements that get people across the line without making assumptions that this is higher than it is.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I agree with that, Claudia. What I was getting at was a policy recommendation with regard to those who would choose to consume, in whatever way makes sense, the ELPD services. So it's not saying that ILPDs are required to, but it's saying that if they would like to do that then there ought to be a set of patient requirements that would have to be defined, but we can lay out some principles. And I think they're all here and they're in the ELPD recommendations. But I don't think we've made that firm a connection yet.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
You've threaded it in a nice way to address my issues.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I think I'm hearing that we would want to have a fifth policy consideration or recommendation here about a set of requirements for an ILPD operator that wants to connect to the ELPD that they will need to meet, so that there will be a set of requirements, I guess, is the way to put it. ILPD operators that want to

connect and benefit from the connection to an ELPD would be expected to meet a set of participation requirements.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, leaving aside for the moment the question of why they would find that valuable, which is yet to be determined, and I hope that they do. They ought to have some requirements.

Hunt Blair – OVHA – Deputy Director
To that point, Micky, when you said before ILPDs consuming ELPD data …, can you say more about what you mean? I'm going back to point 10 on slide 18, where we talk about there being an appropriate linkage between the ILPD and the ELPD. Part of the complexity I think is we've obviously gotten into a lot more detail about the ILPDs after the ELPD discussion, but I'm trying to understand how you would have, I guess you could have an ILPD that would reference but not actively link to an ELPD address. But I'm not understanding how much value there would be for an ILPD to function independently of the ELPD infrastructure.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I guess by consume I was thinking very generally to say, to the extent that we've talked about this link being that. At the entity level, I would have entity level information related to routing, related to addressable nodes and related to security credentials. As an ILPD sort of the roll up or the linkage would be that I have individuals who map to those entities listed in the ELPD and so I'm consuming that information as a service to fulfill whatever needs I have for the transaction that I'm going to be brokering or initiating or receiving. So it's just sort of in that loose concept that I was thinking about linkage.

On your second point, I guess to me—and this goes back to something I was thinking before—is that for a while I think until an ELPD is launched the ILPDs, they're already many, many ILPDs. They have all the information they need to fulfill the transactions that they were built for, so some of what we might think would be in an ELPD and we've sort of made a distinction between saying what would be in an ILPD versus what would be in an ELPD, right now the ILPDs in existence have everything.

Hunt Blair – OVHA – Deputy Director
Right, and I was thinking of that earlier point that you were making also, and Walter, that's kind of the point that I was trying to raise in the e-mail last week about future states versus the current state. I guess what I think would be helpful in addition to the recommendations that we've laid out here, is at some point—and I don't know what the appropriate group is to do this, but—it seems as though we need a map of how we envision the transition from, Micky, what you rightly say. There are tons of ILPDs. There are more that are popping up all the time, in part because ONC is asking state grantees to create them, and I think that I'm not alone in having difficulty in seeing the path to transition. I understand at the conceptual level how it's all going to happen, but I think that there's an opportunity for providing some clarity in guidance to the community as a whole about how we see this sequencing, because I know that there are a lot of questions out there about how that's really going to happen.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

W
I was just thinking that we're eager to put our recommendations forward, and I don't think you're saying it's time to stop the train, but I think you're saying let's not live in a conceptual world, let's live in the real world. Maybe there's some work to be done, either in the context of the … or maybe there's a smaller team of this group that would like to keep on talking in meetings to come up with some of that guidance.

Maybe there's a way to unhinge that a little bit, some of these recommendations, or maybe even make a recommendation that it would be useful to have a forum to discuss those implementation issues.

Hunt Blair – OVHA – Deputy Director
I definitely am not in any way suggesting we stop the train. I'm all about moving this along as quickly as possible and I think that's what the folks out there in the states and the members of the Provider Directory COP are interested in. But I think that your idea of a recommendation about quick connecting of the vision current state to future state could be very helpful to folks, just to round it all a little bit more, because I think that's part of what's missing.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Does it make sense to tee that up as being something that we'll put together for the next Policy Committee meeting, because that's what you were suggesting, right, Claudia?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I'm a little leery because we have a lot of other work on our plates. Now if you want an approach, it may be—

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Hello?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, go ahead.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I'm sorry. I was interrupting Claudia. Go ahead, if you want to finish your thought.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
So I guess I'm feeling like there are some critical other issues that we haven't gotten to yet that aren't provider directory related that need to be the priority of the next month or two. If we feel like we can also take on scoping that out, I think that's a great idea. Or, and maybe it's just a group of people that are meeting on their own that's not as much as these official workgroups. I don't know. I know from a staff level we're going to be a little stretched over the next couple of months to do all the things that we're doing.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
What I wanted to suggest is, because I think this will, in effect, end our work as a taskforce on provider directories, the day we deliver this, on Wednesday to the Policy Committee. So my suggestion is that I really want to pick up on the concept of convening a forum, if you will, to facilitate a discussion on how we operationalize this with pictures, and again you talk about even developing a "use" case for how HIEs would operationalize ILPDs and then connect to ELPD and all this. So I think that would be a natural next step for our taskforce not to stretch work and the participation of our experts in our taskforce. But I think now that we have completed our policy recommendations in both ELPDs and ILPDs it will be a matter of conceptually creating how this gets operationalized and creates this map between the current state and the future. I think it will be, and I will certainly be happy. Jonah dropped already so I don't—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
We'll volunteer him.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO

Volunteer him. But I certainly see that this will be a very focused, targeted, limited activity of our taskforce that we can continue to work on over the next couple of months and bring in some additional expertise and participation from HIEs directly so that we can contribute on how they're doing—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Walter, can I suggest that maybe we should have an offline call about this, because it sounds like there's different ideas to take this to a next level related to thoughts about operationalizing them. I think what you're proposing is a little bit more elaborate than I think what I heard Hunt suggest, but that just means that it seems like there's directionally some energy to think a little bit more about operationalizing some of the concepts. What we need to figure out is how to do that in a way that is both meaningful and helpful, but also respects the time commitments of everyone, including ONC staff as well as workgroup participants who we're going to be calling on to deal with the meaningful use stuff as well going forward. Maybe I'll just suggest that we have an offline call that we can help to schedule with Hunt and you and Jonah and anyone else who wants to participate to try to think about that next step.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Perfect. Let me finish that up. Again, I want to thank all our members of our taskforce for their contributions. I'm going to turn it back to you, Micky. This is what we intended to present on Wednesday with approval by the workgroup, so I'll turn it back to you.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Well, thank you, Walter and Jonah in absentia for the terrific work here, and for all of the workgroup members who participated in this taskforce. It's incredibly comprehensive and very painstaking work, so we really appreciate your diligence and thoughtfulness. Are there any concerns? We've had a number of opportunities for people to have comments along the way, and I think that Walter and Jonah have addressed and are going to modify accordingly according to some of the comments that we had during this call, but I didn't hear any other strong concerns along the way. Let me just pause here and first I'll see if David has any additional thoughts on this, but otherwise I guess I would recommend that we put it to the workgroup to recommend that this be our recommendation to the Policy Committee on Wednesday, I believe it is.

David Lansky – Pacific Business Group on Health – President & CEO
Micky, I support that next step.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Is there anyone who would have concerns about that?

M
No.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Sorry. I think I heard that as a no.

M
I think everyone's comfortable ... still on the phone.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
All right, terrific. Then we'll take that as the Information Exchange Workgroup affirmation that we will make these our recommendations at the Policy Committee meeting on Wednesday. Thank you, again, Walter and Jonah for all of your work on this.

We're going to move forward to talk about the Meaningful Use Workgroup. As I said, I know we're running short on time, but I think what we wanted to accomplish on this call was first we wanted to be able to give the amount of time that Jonah and Walter needed to get through the ILPD conversation and discussion because that is an affirmative recommendation we're going to be making on Wednesday. So we wanted to make sure that everyone felt comfortable with that, but I think as it relates to the meaningful use considerations, that we're going to now move from a workgroup perspective.

What we really wanted to accomplish on this call was really more about process and setting the stage for our meeting on March 15th. As well as for the approach that we might want to take over the coming months as we think about meaningful use stage two and stage three generally. And start to drill down into the specific HIE kinds of transactions that are buried in the recommendations insofar as we've seen an initial set of recommendations that are out there for public comment.

Turning to slide 23 here, here is the schedule right now for meaningful use stage two input. On February 25th, the public comment period closed, as I think as everyone probably knows. On March 15th, we have our in-person meeting and hopefully you can attend that. I would love as many people as we can get in person, because I think this is important work and will be pretty focused work, so having as many people in person will be very important.

The Meaningful Use Workgroup is going to, in April and May, start to look at the public comments and then start to present their recommendations to the Policy Committee in May based on their further deliberations as well as any other input they've gotten. The thought from our workgroup perspective is that we start to have our deep consideration of the stage two recommendations. As we heard from George Hripcsak last time, who is the co-chair of the Meaningful Use Workgroup, the recommendations from the Meaningful Use Workgroup are in effect frozen right now because they were out for public comment and now they're going to be digesting the public comment. They're not doing any work right now because they don't want to get out ahead of the public comment process, so this is a good opportunity for us to weigh in workgroup to workgroup with our thoughts on this.

So the timeline here is March 15th. We'll have our meeting and then I think coming out of that we can work with the Meaningful Use Workgroup on the schedule for being able to provide them with some input. What you have on this slide is a proposal to have two additional Information Exchange Workgroup meetings to finalize our input. One would be the week of March 21st and the other the week of March 28th, in anticipation of our being able to provide input to the Meaningful Use Workgroup before April 5th, which is roughly when we think they're going to be able to review the public comments that have been submitted to CMS.

Between now and then, what we'd like to do—"we" meaning David and I as co-chairs, as well as ONC staff—is digest a little bit what you have on the following set of slides, which is Kory's great effort to pull out from the meaningful use stage two recommendations that are out from public comment. Which ones have health information exchange implications or which ones rely on health information exchange in some significant way, as well as a matrix that was sent out by David Lansky that maybe he can describe briefly for us so we know what we're looking at. But also obviously with the quality measures there's also buried in there a lot of health information exchange expectations and assumptions.

But what we'd like to be able to do for March 15th is fully digest some of that a little bit more and provide it back to you as the workgroup in a way that will facilitate a more focused conversation about transaction types and timing and what have you. Because I think that as we look at it right now, it's not really in a form, at least from my personal perspective, for us to be able to have that focus and detailed level of

conversation that we need. That's the process steps that's alluded to there in the next steps that we'll be getting out to you before the March 15th meeting.

The high level thought on March 15th, and we'll have more detail on this, is to be able to review the objectives that are proposed by the Meaningful Use Workgroup by now, both the objectives and the measures, with a whole bunch of questions. Are these the right measures? Are they sufficiently rigorous? Which ones may be too challenging? Which ones may not be challenging enough? Are there additional adjustments that we might contemplate? That will hopefully be the launching point for us to start to really put to paper a set of concrete input and recommendations for the HIE related objectives in anticipation of that April 5th deadline with the Meaningful Use Workgroup.

On the next set of slides now we just have, as I said, this is just at a high level pulling out from that set of for public comment recommendations, which ones seem to have a lot of Health information Exchange buried in them. Rather than go through these in detail, as I said, we want to digest these further and present them back to you, so rather than go through these in detail, I'd like to just turn to David both for his thoughts on this as well as for a quick description of the quality measures grid that was also passed out. That at least will provide all of you with a background for why you have in front of you what you have in front of you, and will be a good context for the next set of materials that we'll be sending out, which will be based on this raw input.

David Lansky – Pacific Business Group on Health – President & CEO
Again, I don't think we have time to look at this in detail, but if you have a chance, especially between now and the 15th. We'll give you some more structure to that, to look at these two documents, the slide that you have in front of you on the meaningful use functional criteria and the spreadsheet that was attached on the quality measure domains. Both of those have hints as to what kind of information sharing functionality is needed by 2015 to support the meaningful use program.

Now the quality measures piece on the matrix, none of that is cooked yet, so that is really a set of guidance to ONC, which ONC will in turn put out to consultants and experts for fleshing out over the next nine months or so. So in a sense what we have from that matrix is a set of directional signals, but not a set of specifications. I think our job then is assuming that those directional signals are basically right, the question is can we support those directional signals with information exchange capability across the country by 2015. If not, it's really helpful for us to give a signal back to the Quality Measures folks that worthy as these ideas might be they're not feasible or what's the balance point between feasibility and the aspirational direction that they want to send. I hope by the 15th we can get some feedback and by the 5th certainly some feedback to the quality measures branch of this enterprise about what is realistic. And in turn how can we send a signal to the information exchange platforms around the country of what they need to be doing to support the policy objectives for quality measurement.

If you look through that spreadsheet, I think there are three basic concepts that we can talk about more on the 15th. One of them is getting data from multiple sources, not only the EHR in the provider setting, but claims data, patient home-based data, and other sources of information prescribing dispensing data, for example. How do we flow data from those other sources back to the EHR, or how do we flow it to a third party computational platform where the quality measures will get computed. And what are all the implications for standard and so on from that goal.

The second, I think, is patient supply data, both data which you want us to take back into the EHR for care planning purposes, and data that you want to keep out of the EHR because it's a valuation data like patient ratings of patient experience on provider performance. So you don't want to compromise patient privacy but you do want to capture at a provider identified level.

The third thing I think that's implied here is computational tasks across time. For example, we have a number of proposed longitudinal measures where there's a time one and a time two. They may come from different platforms, from different data settings, multiple EHRs or multiple data types, and you want to then compute something across time, how does that happen. I think those are the three. You'll probably see more implications than I've seen as you look through that, but those are the kinds of problems we want to start thinking about for 2015.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Just a process question, for the Quality Measures Workgroup, are you going to be providing that input to the Meaningful Use Workgroup, or is that just really a whole parallel set of recommendations that goes directly to the Policy Committee and then to ONC?

David Lansky – Pacific Business Group on Health – President & CEO
I think the answer is yes. In a sense the quality measures process will work under its own mechanism, and it's actually now going to be deferred until the end of the year before we get feedback from the experts about feasibility of the proposed new measures. The Quality Measures Workgroup will spend the spring and summer hammering down on all the other measures that are part of the re-tooling measures that NQF has done and about 113 older measures that are now being translated and specified for EHRs. What to do with these stage one measures and how should they evolve for stage two and stage three? So there's a path of work under the Quality Measures Workgroup but it is at least coordinated and it's not overseen by the Meaningful Use Workgroup.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. Great, thank you. The last slide, if we can just go to the last slide, please, the one that has the listing of the—I think a little bit further, please.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I think it's this, slide 31.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Oh, I'm sorry. Yes, this is the Appendix. Okay, yes, sorry. There it is. So the thought—and again this is really just sort of a high level concept right now but just in order to give ourselves at least some loose structure to be thinking about. The idea I think is that we want to be able to do is on the 15th be able to start to dive down into some of these details, where the way I've been thinking about this, and, David or Claudia correct me if you think I'm framing this in the wrong way. But in effect you've got the meaningful use stage two, stage three recommendations that are there and you have the quality measure work, and there's a strong implied health information exchange road map underlying all of that. Our job in a way is to pull all that out from those details and be able to present it and think about it in a coherent way that says, okay, so if we're going to accomplish all those things, here's the road map that is being implied by all of that. Then be able to weigh in on which elements of that we think make sense, which ones we think may or may not make sense, and what we think our recommendations are related to that.

That would be the first level of activity in the March, April time frame, which is really just a tee up for us to be able to drill down into the various areas. Thinking about workgroup process, what we want to be able to do is be a little bit more nimble and a little bit more tactical and still respect all the workgroup members' time. So the idea would be that roughly on a month by month basis having a set of workgroups or sub-workgroups here, or taskforces, however we want to think about it underneath the IE Workgroup, that are focused on particular areas and try to spread the joy to a number of different workgroup leads, to be able to lead that effort. But really with an eye toward saying let's quickly identify what we think are the issues

there, and then come up with a set of recommendations that can help move the ball forward. But without having to have us spend too much time on them because we know we have a number of them that we need to really get through before the end of the summer, as we think about how the meaningful use stage two recommendations, with the NPRM and all of that, will start to unfold.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Micky, I think that was exactly right from the thinking that we were doing. And maybe to keep these two things apart just a little bit, we have an immediate opportunity with the timelines of the MU Workgroup to get them input, exactly as you said, on what are the implied pathways and IE requirements in .... Somewhat on a different track, we have a lot of levers we can use to be sure that CH1 succeeds. So I think the purpose of this exercise this summer certainly could play in ..., but equally to plan to us saying, wow, there's been really important technical issues we need to address, or policy issues, or programmatic issues simply to make sure that providers can get to stage one. I think ... apart a little bit I see the work this summer as helping us, and weigh out some of the issues folks are confronting as they're dealing with stage one could have important implications for either ONC's work or somebody else, state's work, or CDC's work, or vendors' work to address what some of the various folks are experiencing.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Thank you. Unless there are any other comments, I know we're really running short on time and I need to turn it over to Judy for public comment. Are there any—

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Micky, just a very quick question, so the expectation is that we would be able to join one or more of these workgroups?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Absolutely, you can join everyone.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
My thinking is that it's always good to have a couple people on a hook, that we don't necessarily need to formalize workgroups. We might do more of a just in time approach, where a couple of interested people are working off line with staff to just scope out the issues and bring that forward to the broader group for discussion. So that we're not needing to drive all the way necessarily to recommendations but have a huge value in just quickly going through a bunch of critical issues and then figuring out what challenges we're facing, what opportunities we might have, and some alternative pathways forward. I know we have a huge ability to dig in a very detailed way, but we were cognizant of the fact that there's a lot to get through in a short time and wanted to come up with a less burdensome way to do that that would allow us to get through a lot quickly. If you're interested in being part of that little tiger team that's going to work on that issue, just let any of us know.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, great. Thank you. Judy, can I turn it over to you for the public comments?

Judy Sparrow – Office of the National Coordinator – Executive Director
Absolutely. Operator, can you please check with the public to see if anybody wishes to make a comment?

Operator
We do have a question.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you. Could you please identify yourself?

Linda Syth – Wisconsin Medical Society – COO
My comment is to slide 14 of the presentation that Walter did. I think item one, where it says individual providers not entities or organizations should be listed in the ILPD. For outsiders, especially as we've been working with the community of practice, that might be a little too rigid because as we're finding out in the transition they are going to certainly be there and as we move from the current state to the future state I think people take some of this information maybe a bit too literally. So I would change the "not" and soften that piece.

(Background speakers.)

Judy Sparrow – Office of the National Coordinator – Executive Director
Go ahead. Hello? Linda, are you through? Do we have any other comments?

Operator
We do not have any other comments at this time.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, great. Thanks. Thank you, everyone. I apologize we got into a little bit of a time crunch here at the very end. But I very much appreciate everyone's engagement. Please look out for materials for the March 15th in-person meeting. I look forward to seeing you all there.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Thank you.